State of Vermont
Green Mountain Care Board
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Report to the Legislature

REPORT ON THE GREEN MOUNTAIN CARE BOARD'S ANALYSIS OF HOWARD CENTER'S BUDGET

In accordance with Act 54 of 2015, Section 28

Submitted to the
House Committees on Appropriations, Health Care, and Human Services; and the
Senate Committees on Appropriations, Health and Welfare, and Finance

Submitted by the
Green Mountain Care Board

January 29, 2016

Introduction

Act 54 of 2015 requires the Green Mountain Care Board to analyze the budget and Medicaid rates of at least one designated agency (DA) using criteria similar to those used in the Board's annual review of hospital budgets under 18 V.S.A. § 9456. 2015 Vt. Acts & Resolves No. 54, § 28. As part of the review, the Board must consider whether designated and specialized services agencies (SSAs) should be included in an all-payer model. Finally, on or before January 31, 2016, the Board must recommend to several committees whether the Board should conduct an annual review of all DAs' budgets and whether DAs and specialized services agencies should be included in an all-payer model. *Id.*

Beginning in September 2015, we reviewed the Fiscal Year 2016 (FY16) budget of the State's largest DA, Howard Center. As described below, Howard Center was a willing and helpful participant, and we thank the many members of its team who put time and energy into the process.

As a threshold matter, we note that our review was limited in scope. We gathered information from Howard Center using a process as similar to our hospital budget review process as feasible. We did not audit the entity's performance or finances, nor did we assess the effectiveness of its programs or its compliance with its contracts or grants. Those matters are beyond the scope of our review and this report.

In summary, our analysis revealed that Howard Center's current budget does not adequately fund the institution's desire to accomplish its client service missions, as evidenced by lengthy waiting lists, over 100 staff vacancies, and the closure of valued community services. Indeed, the agency has budgeted no operating margin and very low days cash on hand in 2016. Medicaid funding, which comprises over 80% of Howard Center's revenue, has decreased from 2014 to 2016. Further, we believe that the underfunding and resulting understaffing of this institution results in substantial unmet needs, which in turn affects many Vermonters.

While we see a need to share information from the DAs and the relevant state agencies with the Board, we do not recommend that the Board assume a new, independent review process. Instead, we recommend requiring the Board to continue to develop the all-payer model, in which the State proposes to create a pathway to integrate mental health and substance abuse services and long-term services and supports over time. This approach, reflected in the recently released all-payer model term sheet,[1] demonstrates the Board's view that the DAs and other community-based providers must play a critical role in the evolution of our health care delivery and payment.

Below, we provide context by defining key terms, briefly describing our hospital budget

[1] The all-payer model term sheet documents released on January 25, 2016 are available at the links below:
Term Sheet:
http://www.gmcboard.vermont.gov/sites/gmcboard/files/Press/GMCB_APM_Term%20Sheet_App%20A%20merged-FINAL.pdf
White paper explaining Term Sheet: http://www.gmcboard.vermont.gov/sites/gmcboard/files/Press/APM-Compaion-Paper-Formatted-FINAL.pdf
One-page summary: http://www.gmcboard.vermont.gov/sites/gmcboard/files/Press/APM-1-pager-FINAL.pdf

review process, and explaining the steps we took to review the Howard Center's budget. Then we set out the results of our review, as well as the recommendations called for by Act 54.

Definitions

Designated Agency: A public or private nonprofit designated by the Commissioners of the Departments of Mental Health (DMH) and Disabilities, Aging, and Independent Living (DAIL) to "plan, develop, and provide . . . community mental health or developmental disability services" to Vermonters. 18 V.S.A. § 8907(b). DMH and DAIL are directed by law to ensure that such services are available to Vermonters who need them, *id.* § 8907(a). They fulfill that charge through a statewide network of DAs.

Specialized Service Agency: These entities supplement the DAs in meeting the developmental and mental health service needs of Vermonters by providing distinct approaches and services to meet specified service needs.

All-payer model: There is no single established definition of an all-payer model; at its most basic level, the term refers to a model in which all payers use the same methodology to pay providers. Vermont has examples of all-payer models in place today, though they rely on a fee-for-service payment mechanism: For example, Medicare, Medicaid, and commercial payers all participate in the Blueprint for Health, and the State worked with stakeholders to create shared savings programs offered by Medicaid and commercial payers that parallel the Medicare shared savings program. The Board, together with the Secretary of Administration, is exploring with the federal government the feasibility of creating an all-payer model that would replace fee-for-service with a different payment methodology for providers who choose to participate. For this report, we use the term to mean a health care payment approach in which all payers pay providers using a common methodology that moves away from fee-for-service and gives providers the flexibility they need to lead health delivery change.

Hospital Budget Review

Because we used our experience in reviewing hospital budgets as a backdrop for our analysis of Howard Center, we provide a brief description of our hospital budget process. Every year, the Board must review and establish each hospital's budget by September 15, and must issue a written order reflecting its decision by October 1. 18 V.S.A. § 9456(a), (d)(1). The Board may adjust a budget established under this section upon a hospital's showing of need based upon exceptional or unforeseen circumstances, 18 V.S.A. § 9456(f), or based on the Board's independent review of a hospital's performance under its budget. GMCB Rule 3.000, *Hospital Budget Review* (Rule 3.000) § 3.401.

Process:

To meet the September 15 deadline, the Board requires the hospitals to submit proposed budgets for the upcoming fiscal year[2] on or before July 1. Rule 3.000, § 3.203. The Board's staff analyzes the data, works with the hospitals to resolve any gaps or questions, and queues up the

[2] The hospitals' fiscal year is defined in statute as beginning on October 1. 18 V.S.A. § 9454(b).

information in advance of each hospital's public hearing. Typically held in late August, the public hearings provide an open forum for each hospital to come before the Board, explain its budget, prior year performance and priorities going forward, and to answer questions from the Board, its staff, and the public. The Board uses that information to supplement the budget submissions and assist in making decisions about each budget. If outstanding issues remain, the Board will schedule additional public sessions with specific hospitals. Once the process is complete, the Board deliberates and votes on each hospital's budget in open session.

The Board's staff and the hospitals invest a great deal of time in the process prior to July 1. By March of each year, the Board issues written filing instructions to the hospitals. Staff then works with the hospitals throughout the spring to answer questions and make sure that the hospitals have the information and guidance they need to file their budgets by July 1. In 2013, the Board purchased and implemented a software tool which has greatly streamlined review of the budget submissions while improving data acquisition and integrity.

Substance:

After its first round of hospital budget review in 2012, the Board decided to develop a clear regulatory policy designed to exert downward pressure on budget growth. Through a robust public input process in late 2012 and early 2013, the Board adopted a policy governing hospital budget review for fiscal years 2014-2016, as well as separate policies on hospital budget enforcement, provider practice transfers and acquisitions, and community needs assessments.[3] The hospital budget review policy established two key parameters for the hospitals' FY16 budgets: First, the Board set a net patient revenue (NPR) growth cap of 3.0% over the hospitals' FY15 budget bases. NPR includes payments hospitals receive from patients, government, and insurers for patient care, but does not include revenues from activities such as cafeterias, parking, and philanthropy. A key indicator used to assess changes in hospital budgets, NPR generally tracks closely with hospital expenditures.

Second, the Board established an additional NPR growth allowance for FY16 of up to 0.6% for "credible health reform proposals." Hospitals bear the burden of convincing the Board that such revenue will be invested in building a reformed delivery system. The Board offered the following categories as examples of reform initiatives that it may deem credible:

a. Collaborations to create a "system of care"
b. Investments in shifting expenditures away from acute care
c. Investments in population health improvement
d. Participation in approved payment reform pilots
e. Enhanced primary care and Blueprint initiatives
f. Shared decision making and "Choosing Wisely" programs

The Board chose NPR as its key budget measure and target for FY14-16 because it is a good proxy for the amount of "new money" each hospital intends to spend in a given year. In addition to NPR, the Board establishes each hospital's proposed "rate increase": the overall average amount by

[3] The policies are available at: http://www.gmcboard.vermont.gov/hospital_budgets/policies.

which a hospital must increase its prices to attain its NPR increase.[4] The review process, supported by the Board's policy on provider transfers and acquisitions, has enabled the Board to keep NPR growth within its target, and at historically low levels, for FY14-16.

Howard Center Budget Review Process

Howard Center, like all DAs, operates on the state fiscal year beginning each July 1. Board staff contacted Howard Center in September 2015 to begin planning the review timeline and necessary exchange of information. Our staff met with Howard Center representatives in early October to establish the initial submission of information, including the Center's current (FY16) budget, general ledger, and system-level information. Through early January 2016, our staff worked with Howard Center staff to refine and supplement its information, in an effort to align it as closely as possible to the information submitted by hospitals in the hospital budget process.

On January 13, 2016, Howard Center representatives appeared before the Board at an open meeting designed to resemble a hospital budget hearing. The company presented its budget information and spent considerable time answering Board questions and responding to public comment. The Board found the hearing informative and helpful, and found that Howard Center was thorough and effective in presenting and answering questions. Board staff also found Howard Center to be responsive and thorough in the work leading up to the hearing.

Results of the Board's Review

Systemwide information

Howard Center presented helpful information about the statewide DA and SSA system.[5] The agencies provide services in six main program areas:

- Adult outpatient: Services for adults who do not have prolonged serious disabilities but who are experiencing emotional, behavioral, or adjustment problems severe enough to warrant professional attention
- Community rehabilitation and treatment: Services for adults with severe and persistent mental illness
- Developmental disabilities services: Comprehensive services for Vermonters with

[4] The actual changes in prices charged by each hospital will vary across service lines and goods and services provided by the hospital. The actual prices paid by each commercial payer can vary because prices are established through contract negotiations. Medicaid and Medicare prices are not typically negotiable, and reimbursement is instead established through those payers' unique fee schedules and update factors. In addition, rates can vary based on changes in other elements of a hospital's budget, including the distribution of Medicaid's disproportionate share hospital payments and changes in bad debt and free care.

[5] The information summarized in this report is derived from Howard Center's submissions and our staff's analysis, available on our website at the following links:
GMCB staff analysis: http://www.gmcboard.vermont.gov/sites/gmcboard/files/Hospital/GMCB-DA-Howard-Ctr-MDReport-Final_1_26.pdf
Howard Center narrative:
http://www.gmcboard.vermont.gov/sites/gmcboard/files/Hospital/Howard_Center_Narrative.pdf
Howard Center responses to GMCB questions:
http://www.gmcboard.vermont.gov/sites/gmcboard/files/Hospital/Howard_Center_Responses_To_Questions.pdf

developmental disabilities, including home supports, respite, employment and community supports, clinical, and transportation
- Children and families: Services to assist children and families undergoing emotional or psychological distress
- Emergency services: 24-hour, 7-day telephone and in-person services available to people experiencing acute mental health crises
- Advocacy and peer services: Broad array of services provided by trained peers to support recovery

Vermont's DAs and SSAs employ (or contract for services with) a workforce of over 13,000, amounting to total compensation of $262.5M in FY15, who in turn have served over 35,000 clients and provided services to over 50,000 individuals. The DAs' revenue stream is actually a complex grouping of multiple rivulets: Howard Center listed 26 different funding sources, most administered by the state through DMH, DVHA, and other agencies. DAs are reimbursed for their services via different methodologies: fee for service, bundled rates, grants, individual program contracts, monthly case rates, and daily and monthly waiver rates. Adding to the complexity, the programs they run have different eligibility criteria, documentation requirements, billing structures, reporting, and measures. In short, DAs are administratively complex entities.

Howard Center's FY16 Budget

Measured in FY14 expenditures, Howard Center comprises approximately 22% of the DA system's $365M total. In FY15, the organization served 8,467 clients, a 1.2% increase over FY14, providing the wide range of services listed above.

Howard Center's FY16 budget reflected $89.6M in revenue, a 1.0% increase over its FY15 budget and approximately 4.6% greater than its actual FY15 revenue. As mentioned above, that revenue comprises dozens of separate streams and over 80% flows from the State, with 73% coming from Medicaid. Howard Center assumed a 0.875% annual Medicaid increase (1.75% effective January 1, 2016), but subsequent to adoption of its budget, the Legislature approved an annual Medicaid increase of 0.22%, and reimbursement rates for group therapy and applied behavioral analysis were reduced 75% and 60%, respectively.

The agency's expense budget assumes an increase of just under 1%, which includes a 3% increase in fringe, a 2% increase to base compensation, and a 1% onetime compensation increase for length of service. In order to accommodate those compensation increases, the agency made substantial effort to minimize all other costs that included difficult decisions to close or reduce programs, and increased staff caseloads and productivity expectations.

The agency made staff compensation a top priority to address significant recruitment and retention challenges, as reflected by its current tally of 104 unfilled positions.[6] The agency also

[6] In its soon-to-be-released "White Paper on Barriers to the Long Term Sustainability of the Provider Work Force," Vermont Care Partners pegs the current number of vacant positions in Vermont's DA/SSA system at 350, with average annual turnover of 27.5% over the past three years. As of the time of this writing, Vermont Care Partners anticipated that the White Paper would be available on its website, www.vermontcarepartners.org, shortly after the due date of this report.

reduced its total FTEs by 4.1% in order to control expenses. While the reduction in staff enables the organization to increase compensation, it also presumably results in increased workloads. We believe that underfunding of the organization, resulting in significant staffing gaps and challenges, in turn leads to substantial unmet needs in the community Howard Center serves and hardship for those individuals and families.

Administrative costs comprise 8.8% of the expense budget. Days cash on hand has increased from 19.5 in FY14 to 29.3 in FY15 (or 38.2 and 46.5, respectively, if the $4M Board-restricted endowment is included). The Municipal Capital Markets Group recommends 60-90 days cash on hand for the industry. Current assets increased from $10.5M in FY14 to $13.1M in FY15. The agency's operating surplus increased from ($642,485) in FY14 to $536,723 in FY15, and the FY16 budget projects $0 operating surplus.

In sum, we find that the agency has constructed a responsible budget that maintains needed community services, controls expenses while allowing limited compensation increases, and does so within the reality of limited revenue growth. But indicators like days cash on hand, operating surplus, vacant positions (104), and the number of individuals requesting services that Howard Center cannot immediately address cause us to question the sustainability of the DA system. Despite its responsible budgeting practices, as presently funded the agency struggles mightily to recruit and retain the staff it needs so it can meet its programmatic and statutory mission. In spite of those challenges, it is equally clear to us that Howard Center provides great value to the community through the dedication and skill of its staff and management.

Recommendations

The two questions posed by Act 54 are best answered against the backdrop of Vermont's and the Board's payment and delivery system reform efforts. Act 54 also directed the Board and the Secretary of Administration to explore an all-payer model with the federal government. *See* 2015 Vt. Acts & Resolves No. 54, § 1. As part of our efforts to fulfill that instruction, on January 25, 2016, six days before this report is due, the Governor released for public review and comment a draft term sheet outlining the model the State is proposing to the federal government. Given that we are at a pivotal moment in the development of a reform platform with profound implications for our health care system, including the DAs, we recommend refraining from investing in a new Board review process in favor of continuing to work on the all-payer model, which includes a pathway for integrating mental health and substance abuse services.

1. Board review of DA budgets.

We do not recommend creating a new DA review process at the Board at this time. As described below, other state agencies already review the DAs finances and operations. We recommend instead that the Board coordinate with the other parts of state government that interact with the DAs so the Board can better understand how its regulatory and innovation duties affect the DAs (and vice versa), especially if an all-payer model is implemented.

Our understanding is that DMH already performs a review of the DAs, though limited to the funds that department provides the DAs. DMH's review includes uniform reporting standards, annual budget instructions, Medicaid funding caps, an electronic financial system for collecting

budget information, monthly monitoring of established key performance indicators, and an audit and "true up" that examines the performance related to the cap once the budget year is completed. DMH also gathers and integrates information collected by DAIL from the DAs.

That information is sent to the Agency of Human Services' (AHS) Central Office. AHS then prepares "Master Grant" agreements with all the DAs that describe the funding streams and the programs and services that the DAs will deliver.

Rather than creating an additional, duplicative DA review function at the Board, we recommend that we work with AHS and its various departments that contract with the DAs and SSAs[7] to develop a reporting construct that will provide the Board with a comprehensive view of the DA system, enabling us to better understand the system's finances and operations. Ready access to such information will inform and assist our existing regulatory processes, as well as our efforts to understand the regulatory requirements of a potential future all-payer approach. Information from AHS and the contracting departments and the DAs would be discussed during our open meetings, similar to the hospital budget hearings. We believe this approach would provide valuable information to the Board, the Legislature, other state agencies, the public, and the DAs, and would allow for transparency and public participation.

In addition to duplicating efforts already in place in other agencies, a new review process at the Board would require a large allocation of additional resources not presently our FY16 or proposed FY17 budgets. This exploratory review of a single DA required extensive staff time and Board attention, and a willingness on the part of our staff to go above and beyond their already full workloads to assist in this important analysis. If this were to become a mandated function of the Board, we estimate, albeit very roughly, that we would need two FTEs plus software contractual support, and a minimum cost of $330,000. Without those resources, we would be unable to perform this task even if it were assigned to us by law.

2. Potential inclusion of DAs and SSAs in an all-payer model.

As noted above, the all-payer model term sheet provides that the State will define a pathway to assess whether and how to include mental health services, substance abuse services, and long-term services in the financial targets at the heart of the all-payer model. *See* Vermont-CMMI All-Payer Model Term Sheet (Proposed Jan. 25, 2016), at pp.7-8.[8] More specifically, if the all-payer model moves forward, the State will facilitate a process designed to determine whether and how the State and these providers can ready themselves for including these providers in the all-payer model financial targets.

This approach recognizes that the services provided by entities like the DAs and SSAs are critical to our evolving health care system's success in meeting Vermonters' needs and moving towards financial sustainability. The model would, at least at the outset, be centered around a group of participating health care providers, most likely an ACO such as OneCare, that is

[7] As we learned through our review of Howard Center, those departments include DMH, DAIL, the Department of Children & Families, and the Department of Health.

[8] The Term Sheet is available on the Board's website at: http://www.gmcboard.vermont.gov/sites/gmcboard/files/Press/GMCB_APM_Term%20Sheet_App%20A%20merged-FINAL.pdf

financially able to take on risk in connection with providing a population's health care. The risk-bearing organization would be subject to the growth targets agreed to between the state and the federal governments. The community-based services the DAs and SSAs provide are necessary to control the overall cost of care by reducing the need for hospitalization and more acute, expensive services and, more importantly, to serve the needs of some of our most vulnerable Vermonters. Therefore, the DAs play a key role in moving Vermont towards an integrated health system, albeit a different role from the organization(s) that would bear the financial risk at the outset. And our review of Howard Center underlines the need to develop an integrated, all-payer solution that does a better job than the current approach in letting the DAs and SSAs succeed in the critical work they do.